TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
MELBURN HUEBNER MD

**Respondent Name**
TEXAS MUTUAL INSURANCE CO

**MFDR Tracking Number**
M4-15-3414-01

**Carrier's Austin Representative**
Box Number 54

**MFDR Date Received**
June 15, 2015

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "I would like to appeal the denial of the above mentioned claim for dates of service 1-20-2015. This patient came to our office with an ankle fracture and we first saw him on 1-6-2015 and at that time he presented us his regular insurance and did not inform us this was an on the job injury. Dr. Huebner recommended surgery at that time but [injured employee] was hesitant so we saw him again on 1-9-2015 and 1-13-2015. On 1-13-2015 his xrays showed that his fracture had started to shift and it was necessary to take him to surgery. At this point it was considered emergent due to the time lapse from the date of injury. We did not obtain a precert and an out of network referral however on the precert code 27814 was used however when Dr. Huebner did the surgery that extensive of a procedure was not necessary and we billed procedure 27792."

**Amount in Dispute:** $1,812.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The following is the carrier's statement with respect to this dispute of 1/20/15. The requestor performed outpatient surgery without preauthorization. The attached documentation of the days prior to the surgery reflect the surgical event of 1/20/15 was a scheduled procedure and not emergent."

**Response Submitted by:** Texas Mutual Insurance CO 6210 E HWY 290 Austin TX 78723

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| January 20, 2015 | CPT Code 27792 | $1,812.00 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.2 sets out the definitions for general medical provisions for medical billing and processing.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-197 – Precertification/authorization/notification absent
   - 786 – Denied for lack of preauthorization or preauthorization denial in accordance with the network contract
   - CAC-W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
   - 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
   - 724 – No additional payment after a reconsideration of services. For information call 1-800-937-6824

**Issues**

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

**Findings**

1. The insurance carrier denied disputed services with claim adjustment reason code CAC – 197 "Precertification/authorization/notification absent", CAC-W3 – "In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal", CAC-193 – "Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly", 350 – "In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal" and 724 – "No additional payment after a reconsideration of services. For information call 1-800-937-6824." The insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

   28 Texas Administrative Code §133.2(5) states "Emergency--Either a medical or mental health emergency as follows:

   (A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:

   (i) placing the patient's health or bodily functions in serious jeopardy, or

   (ii) serious dysfunction of any body organ or part;

   Per medical documentation provided states the following "[injured employee] was appropriately identified in the day surgery area. He is feeling a lot better from this last examination 7-10 days ago. He had a marked amount of swelling, and he now has a positive wrinkle test. He has no tenderness or swelling in his calf. The nature of the injury and nature of the surgery was re-discussed at length with the family including risks and benefits. He indicated his desire to proceed."

   Therefore, medical emergency is not defined in accordance with 28 Texas Administrative Code §133.2(5).

2. For the reasons stated above, no recommended reimbursement is allowed.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature**

| | | |
|---|---|---|
| | | 8/21/15 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.